

Influenza Morbidity Report Form

Please fill in the blank or check the answer for each question



PATIENT INFORMATION/DEMOGRAPHICS		
PATIENT NAME:		DATE OF BIRTH:
Last First Middle		mm / dd / yyyy
ADDRESS: (street, city, zip):		HOME PHONE: ()
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female		COUNTY OF RESIDENCE:
CLINICAL OUTCOMES		
WAS THE PATIENT HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, NAME OF HOSPITAL:
PATIENT DIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
LABORATORY INFORMATION		
NAME OF LABORATORY:		
LAB TEST DATE: Date: / / (mm/dd/yyyy)	TEST METHOD: <input type="checkbox"/> Culture <input type="checkbox"/> DFA <input type="checkbox"/> Rapid	
LAB RESULTS: <input type="checkbox"/> Influenza A <input type="checkbox"/> Influenza B <input type="checkbox"/> Influenza "Not Differentiated"		
VACCINATION STATUS	FIRST REPORTED BY	PLEASE RETURN COMPLETED FORM TO
PATIENT RECEIVED VACCINE IN 2004 <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN MONTH RECEIVED VACCINE <input type="checkbox"/> SEPT <input type="checkbox"/> OCT <input type="checkbox"/> NOV <input type="checkbox"/> DEC	Name/Facility: Phone No. () Date: / / (mm/dd/yyyy)	UDOH Office of Epidemiology FAX (801) 538-9923 OR Your Local Health Department
PLEASE SUBMIT SUPPLEMENTAL INVESTIGATION FORM ON PATIENTS WHO HAVE DIED, BEEN HOSPITALIZED, OR TRAVELED TO ASIA		